94

A. Strategies were developed to try to negotiate with the providers that were needed.
Q. What were those strategies?
A. I don't remember them specifically, but it was how the providers would be approached and who would approach them and, you know, what the alternatives were in the area if we couldn't get particular providers to join the network.
Q. Was any consideration given to providing additional amounts in reimbursement to incentivize participation in the network?
A. I don't recall any discussion about reimbursement.
Q. How long were you the executive director for HMO Blue?
A. Until 1996, I believe.
Q. What position did you move to in 1996?
A. I became the deputy director of Blue Cross Blue Shield of Massachusetts and New Hampshire, LLC.
Q. Let my pen catch up with that for a second. There's a lot packed into that title. Can you help me understand the various aspects of that?

95

A. Yes. At that time Blue Cross of Massachusetts and Blue Cross of New Hampshire had a desire to work together to strengthen the regional presence in the Blue Cross plans, and there was a small group that was designated to work on what that would look like, and I was one of those people.
Q. Was a particular entity created called BCBS of Massachusetts and New Hampshire, LLC?
A. There was an LLC. The title was something like what I described.
Q. What were the parameters under which the two BCBS organizations wanted to work together?
A. Both plans would remain independent of one another, but would collaborate on various activities to improve our position in the marketplace or improve our efficiency as organizations.
Q. Did any aspect of that collaboration include the sharing of provider networks?
A. No.
Q. What sort of areas were encompassed by the collaborative work?
A. Some of the health management programs,

96

whether there were any opportunities to collaborate on the administration of disease management and other health management programs, you know, purchasing kinds of discussions. I can't remember any of the other things we looked at.
Q. What do you mean when you refer to purchasing?
A. Supplies.
Q. Are you referring to gauzes, bandages, things like that?
A. It would actually be more office supplies.
Q. Did that include drugs?
A. No.
Q. How many people were involved in that collaborative effort?
A. Four.
Q. I take it one of them was the director?
A. Yes.
Q. And who were the two who worked below you?
A. There was another person who was at the same level I was, Alan Rosenberg, and then there was somebody who worked at the next level whose name was

97

Sheila Buckley.
Q. Who was the person who was the director?
A. Sharon Smith.
Q. How long were you the deputy director of that entity?
A. About a year and a half.
Q. Did the collaborative effort continue beyond that?
A. No.
Q. So it lasted -- did it last in total for that year-and-a-half time period?
A. Right.
Q. What was the conclusion of that collaborative effort?
A. I don't know exactly what you mean.
Q. Were efforts at collaboration ended, or were they made part of a different process?
A. They were made part of a different process.
Q. And how was that change -- what was that change structure?
A. I don't remember exactly how it was

98

structured.
Q. Was Ms. Smith the director of that effort throughout that time period?
A. For the year and a half, yes.
Q. In 1997, that ended in 1997, correct?
A. I believe it was 1997.
Q. Where did you -- what position did you move to then?
A. Vice president for government programs.
Q. How long did you hold that position?
A. Until 2001.
Q. 2001?
A. Ah-hah.
Q. What were the government programs that you were the vice president responsible for?
A. Responsible for the company's contract with the Medicaid program and with federal government for its Bluecare 65 product.
Q. Now what was the contract in relation to Medicaid?
A. The Medicaid contracts with health plans to enroll Medicaid recipients into their health

99

plans. For some period of time Blue Cross was a contracting health plan to Medicaid.
Q. Now in those situations what amount was Medicaid paying to BCBS of Massachusetts in relation to Medicaid patients who had enrolled in its programs?
A. I don't remember the amount we were paid.
Q. How was it calculated?
A. It was calculated based on a formula that the state, you know, used, and I don't remember the details of the formula.
Q. Was it a capitated amount?
A. Yes.
Q. Were the Medicaid patients then enrolled in a specific BCBS of Massachusetts product, or did they have a choice of product?
A. They were enrolled in HMO Blue.
Q. Did the Medicaid patients have to pay premiums to BCBS Massachusetts?
A. No.
Q. So their entire payment was made by the Medicaid program to BCBS of Massachusetts?

100

A. That's correct.
Q. Now the amounts that BCBS of Massachusetts then reimbursed physicians who treated those patients, were those the same amounts that were reimbursed to physicians who were treating any other HMO Blue patient?
A. I believe so.
Q. So BCBS Massachusetts did not reimburse providers at the same rate as Medicaid would have reimbursed them had the patient had direct Medicaid coverage?
A. Correct.
MR. COCO: Objection.
Q. Do you know what methodologies of Medicaid was used over time to reimburse providers in Massachusetts treating Medicaid patients?
A. No.
Q. Do you have an understanding what methodologies have been used at any time by Medicaid in Massachusetts?
A. I believe they pay fee for service.
Q. Do you know how the amounts in the fee for

101

service schedule are calculated?
A. No, I do not.
Q. Or derived?
A. No.
Q. How long did BCBS Massachusetts have the Medicaid programs that we've been discussing?
A. For several years, but I don't remember the exact time line.
Q. Did the program start when you became VP for government programs, or did they already exist?
A. They already existed.
Q. Were the programs concluded, terminated during your tenure as the VP for government programs?
A. Yes.
Q. Some time in '97 to 2001?
A. Yes.
Q. Do you know when approximately?
A. I don't remember when.
Q. Now the BC65 product, that was a similar product on the Medicare side, correct?
A. It was a --

102

MR. COCO: Objection.
A. It was a contract with the what's now called CMS.
Q. Now CMS would then pay BCBS of Massachusetts a capitated amount, correct?
A. Correct.
Q. And BCBS Massachusetts would then enroll patients in its own product?
A. That's correct.
Q. Now in this case those patients were enrolled in a specific product, correct?
A. Yes.
Q. And that product was the BC65 product?
A. Yes.
Q. That's a product unique to Medicare patients?
A. Yes.
Q. Managed Medicare?
A. Yes.
Q. Now during this time period '97 to 2001, what were you doing on a day-to-day basis in relation to these two programs?

103

A. Evaluating, again, the benefit design. It was different for Medicaid than it was for Bluecare 65.
Q. Let's take them one by one. Let's start with Medicaid.
A. For Medicaid it was making sure that we were in compliance with the contract requirements with the state, and I actually spent most of the time that I dealt with Medicaid evaluating an RFP that they were issuing for a new program and whether Blue Cross would continue to participate in the Medicaid program under this new contract that Medicaid was offering.
Q. Anything else?
A. No.
Q. How about in relation to the BC65 product?
A. For Bluecare 65 I was responsible for the product design, the operations area and the claims processing enrollment, grievance area for Bluecare 65. I was also responsible for compliance, responsible for working on what the supplemental premium would be that we would charge in determining

104

the financial, you know, plan for Bluecare 65. Maintaining the network.
Q. Now we'll come back to BC65 in a little while. Let me ask you a bit more about the Medicaid product.
Why did BCBS of Massachusetts decide to stop participating in that program or to cease contracting with the government to treat Medicaid patients?
A. Blue Cross was losing money on the contract, and the state was in the process of rolling out a new program that was going to require the health plan to manage more complex categories of Medicaid recipients, and the health plan didn't have really the resources and skillset to manage the new populations that the state was asking to be part of the program, so the company had to make a decision whether it wanted to, you know, secure additional resources and expertise or whether it wanted to not continue to be part of the program, and the company made the decision not to continue.
Q. Was the financial problem the fact that

105

the capitated payments that were offered were set at a rate that was too low?
A. Yes.
Q. Were there any other aspects of the financial arrangement that contributed to this being an option that BCBS Massachusetts decided not to pursue?
A. Not related to the financial arrangement.
Q. Now from the perspective of an individual Medicaid patient, how would his options differ if he enrolled in Medicaid directly versus through BCBS of Massachusetts?
MR. COCO: Objection.
A. I don't remember.
Q. Would a patient's financial obligations in terms of co-payments or co-insurance obligations, vary depending on whether they enrolled through BCBS of Massachusetts or directly with Medicaid?
A. I don't remember.
Q. In 2001 did your position change?
A. Yes, it did.
Q. What did you move to in 2001?

106

A. I became the senior vice president for health care quality and cost.
MR. COCO: That sounds like you're about to get into another category. We've been going about an hour.
MR. MANGI: Sure. Let me cover a quick question and then we'll be done.
Q. How long did you hold that position?
A. I still hold that position.
Q. Have you held that position continuously from 2001 to the present?
A. Yes.
MR. MANGI: All right, let's take a break.
(Brief Recess.)
Q. Miss Coneys, I'd like to ask you a few more questions about the staff model HMO for BCBS Massachusetts. I believe you testified earlier that some of the patients who were treated at the community health centers were originally enrolled in products that provided that their treatment would be at such sites, right?
A. Correct.

107

Q. And later on they were enrolled in HMO Blue which included the staff model sites as one option among different sites?
A. That's right.
Q. Other than those patients who came to the staff model facilities through those products, I believe you mentioned that there were also patients treated at those health centers who got their health insurance through other health insurance companies, is that correct?
A. That wasn't always the case, but in the later years that Blue Cross owned the health centers that was true.
Q. Do you have a sense as to what time period that was?
A. It was after HMO Blue was developed.
Q. That's after '91?
A. After '92 actually.
Q. In addition to those patients were there patients who came in for treatment to the staff model HMO sites that had no health insurance?
A. Yes.

108

Q. They were cash-paying patients?
A. Yes.
Q. In relation to the patients who had their insurance from different health insurers other than BCBS of Massachusetts, how was the amount of reimbursement to the Medical East Medical West facilities determined?
MR. COCO: Objection.
A. I don't know.
Q. Do you know whether those other health insurers contracted directly with the community health centers, or did they contract with BCBS of Massachusetts to allow access to all the community health centers?
A. I don't know.
Q. Do you know what methodologies were utilized to reimburse the staff model HMO sites for services rendered with drugs administered to those members of other insurance companies?
A. I don't know.
Q. How about the cash-paying customers? How were the amounts that they were charged determined?

109

A. It was a fee schedule.
Q. Was there a fee schedule specific to services and others specific to drugs that they may be administered in the course of a visit?
A. I don't remember.
Q. Do you know how the amounts of those fee schedules were calculated?
A. I don't.
Q. Do you know whether the amounts on those fee schedules were intended to equal the costs to the facility of providing those services or acquiring those drugs, or did they also incorporate an element of margin?
A. I don't know.
Q. Between the time period that you were executive director of the Braintree site, were there cash-paying customers being treated at that facility?
A. Yes.
Q. Was it your expectation that your site, that had some profitability issues, would be charging those patients an amount exactly equal to

110

the cost of rendering services and administering drugs to them?
MR. COCO: Objection.
A. I don't remember.
Q. Did you have an expectation one way or the other in terms of whether you would bill them purely at cost for everything or at some amount higher than cost?
A. I don't remember ever having any discussions around that.
Q. Did you have an expectation one way or the other?
A. I did not.
Q. The fee schedules that determined how much was paid by a cash-paying customer, were those, during the time you were executive director of the Braintree site, maintained in paper format?
A. I don't remember ever seeing the fee schedule in paper or otherwise.
Q. The time period -- but you're aware that those fee schedules did exist, correct?
A. Right.

111

Q. During the time period that you were executive director of the Braintree site, was there any sort of electronic technology utilized at the site such that could have housed fee schedules?
A. There were computers that were used.
Q. Do you have any understanding as to whether or not fee schedules in that late '80's, early '90's period, were maintained on computers?
A. I don't know.
Q. Did the staff model facilities maintain any fee schedules other than the ones used in determining the amounts that would be paid by cash off-the-street uninsured patients?
A. No.
Q. So if one were to look through files of staff model HMO's, one came across fee schedules, they would be specific to these cash-paying uninsured patients and the amounts they were charged?
MR. COCO: Objection.
Q. Is that accurate?
A. Could you say it again?

112

Q. Sure. If I were to look through the files of the Braintree site or other staff model HMO sites and came across fee schedules, would those be fee schedules determining the amounts that would be paid by these cash-paying patients, the uninsured patients who would come in off the street, or could these fee schedules relate to something else?
MR. COCO: Objection.
A. I don't know.
Q. Well, would there be any other fee schedules that you are aware of other than the fee schedules we've discussed relating to cash-paying patients?
A. There are none that I'm aware of.
MR. COCO: Objection.
Q. Now in 2001 you came to your current position which is VP for health care quality and cost?
A. Correct.
Q. Is it just cost or cost containment?
A. Just cost.
Q. What are your responsibilities in this

113

position?
A. I'm responsible for the company's health care quality strategy and programs and the company's health management and utilization management programs.
Q. Anything else?
A. No. Under the quality area I am responsible for all the accreditation activities for the various entities that accredit health plans.
Q. So accreditation of health plans or physicians?
A. Health plans.
Q. What sort of entities provide accreditation to health plans?
A. National Committee on Quality Assurance, NCQA.
Q. Now have your responsibilities changed in any way between 2001 and 2006?
A. Not really.
Q. I'd like to talk first about the health care quality aspect of your role. Other than accreditation of BCBS of Massachusetts, what other

114

issues do you deal with in relation to health care and quality and strategies?

A. I deal with the evaluation of quality metrics that are used in the industry and how they should be applied in Blue Cross Blue Shield of Massachusetts programs. I also deal with a hospital quality reimbursement program as part of our contracts with the hospitals in the state, and I'm responsible for the company's peer review activity, patient care assessment activity.

Q. Anything else?

A. I think that's pretty much it.

Q. What do you mean when you refer to quality metrics?

A. There are various nationally industry recognized ways in which the industry measures the quality of care that patients receive in the health care system, and my area is responsible for evaluating those metrics and deciding how we can use those measurement systems and metrics to help promote and improve quality of care in the health care system.

115

Q. Is quality of care assessed through service of patient satisfaction?

A. That's one method.

Q. What other methods do you utilize?

A. Through claims.

Q. I'm sorry?

A. Through claims.

Q. Through claims? How do claims provide information about quality of care?

A. We can use claims to determine if patients are receiving the treatments and tests and care that's suggested based on the conditions they have. We also can identify where there have been complications from procedures that were done from claims.

Q. After quality metrics the second aspect of the quality you earlier mentioned is hospital quality. I believe you said reimbursement programs?

A. Incentive program. That's --

Q. What are those?

A. That's part of our -- when we contract with hospitals and negotiate our reimbursement terms

116

with hospitals, we include in that an incentive program where they can earn additional money from us if they achieve agreed upon improvements in quality metrics.

Q. Is this the same quality metrics we've just been discussing?

A. They are some of them, yes.

Q. Other than your assessment of your work in relation to hospital incentive programs, do you play any role in hospital contracting?

A. No.

Q. Are you familiar with Medicaid shortfall payments or government shortfall payments?

A. Only in hearing them as a general topic in the company.

Q. What's your understanding as to what those are?

A. Payments that the hospitals look to us for to make up for the money they're not getting from Medicaid.

Q. If a hospital is not getting a sufficient amount of reimbursement from Medicaid, how does that

117

involve the BCBS of Massachusetts?

A. I don't know.

MR. COCO: Objection.

Q. Have you gained, at any point, any understanding as to why BCBS Massachusetts makes these payments?

A. No.

Q. Do you have any idea as to why it makes the payments?

A. No.

Q. Is it your understanding that those payments are made on a regular basis to hospitals?

A. I don't know how they're made.

Q. Are you aware if Medicaid shortfall payments only as a concept, or do you know whether or not they've actually been implemented and applied?

A. I'm aware of them as a concept.

MR. COCO: Objection.

Q. Who's responsible for handling Medicaid shortfall payments at BCBS of Massachusetts?

MR. COCO: Objection.

118

A. I'm not sure there's anybody who owns Medicare shortfall payments at Blue Cross Blue Shield of Massachusetts.
Q. Who's in charge of the hospital contract?
A. Deb Devaux.
Q. Are you familiar with the fact that BCBS of Massachusetts is in the process of changing its methodology for reimbursing hospital outpatient departments for drugs administered to its members?
A. No, I'm not.
Q. Are you aware of the fact that BCBS Massachusetts is moving that setting from a percentage of charge-based methodology to the AWP-based methodology?
A. I'm not aware of that.
Q. Are you familiar with the term percentage of charge?
A. Yes.
Q. What's your understanding as to what that means as a reimbursement methodology?
A. It means that we pay a percent of what the charge is.

119

Q. What's the charge?
A. Whatever the provider charges for service.
Q. In the course of your tenure in the industry, when's the first time you heard of the term, AWP?
A. When I worked for Bay State Health Care.
Q. And what was the time period on that?
A. That was 1979 to 1987.
Q. In what context during your time at Bay State did you have occasion to deal with average wholesale price or AWP?
A. I actually never dealt directly with AWP or the concept of it. I heard it as a term while I was at Bay State.
Q. Do you recall the circumstances in which you heard the term being used?
A. It was related to Bay State's prescription drug program.
Q. Did you gain an understanding at that time of what AWP meant or what it was?
A. I only gained an understanding of what the initials stand for.

120

Q. Did you ever hear AWP referred to as ain't what's paid?
A. No.
Q. Have you ever heard that term before today?
A. No.
Q. After your time at Bay State did you ever, in the course of your work in the industry, have occasion to gain an understanding of average wholesale price beyond what the acronym stands for?
A. No.
Q. Now I'd like to ask you about the NM3 committee. Are you familiar with that?
A. Yes, I am.
Q. What does NM3 stand for?
A. It stands for new medical management model. Steering committee. The NM3 is new medical management model steering committee.
Q. What does that committee do?
A. It evaluates health management program opportunities and evaluates business cases around new programs and existing programs and makes

121

decisions as to whether the company should invest in the development or acquisition of programs.
Q. How long has the NM3 committee been in existence?
A. Since probably 2001, 2002.
Q. Have you been a member of that committee since its inception?
A. Yes.
Q. Remain a member of that committee today?
A. Yes.
Q. What sort of issues has the NM3 committee dealt with over time?
A. It has dealt with the development of disease management programs for diabetes or coronary artery disease, for rare diseases, for depression. It has looked at a Blue Health coach program. It has also dealt with a radiology management program. It has looked at some chiropractic utilization issues.
Q. Do you recall the NM3 committee dealing with the issue of implementing specialty pharmacy programs?

122

A. **Yes.**
Q. Let's turn to a document.
MR. MANGI: Mark this as Exhibit Coneys 001 to the deposition.
(Overview of Specialty Pharmacy marked Exhibit Coneys 001.)
Q. Would you please take a moment to familiarize yourself with that document, and let me know when you're ready.
Have you ever seen the document marked as Exhibit Coneys 001 before?
A. **I don't remember specifically seeing the document before.**
Q. Is the content of the document familiar?
A. **Yes.**
Q. Did you participate in the consideration of the NM3 committee regarding whether or not specialty pharmacy programs should be implemented and if so, what the parameters of those programs should be?
A. **Yes, I did.**
Q. When was this issue first brought up at

123

BCBS of Massachusetts?
A. **I don't remember specifically, but it was a couple of years ago, I believe.**
Q. Do you recall who first raised the issue?
A. **I don't specifically remember who raised it.**
Q. Logistically what were the steps that the committee went through in considering this issue?
A. **I'm sorry.**
Q. Let me clarify the question. Was the NM3 committee the group tasked with considering whether or not to implement a specialty pharmacy program?
A. **Initially, yes.**
Q. Over what period of time did the NM3 committee consider that issue?
A. **I don't remember the specific dates, but it was over a several-month period.**
Q. Can you describe for me logistically what work or analysis was being done in relation to specialty pharmacies during that period of some months?
A. **The part of the work involved educating**

124

the group on what specialty pharmacy services were which is what some of what's in here looks like it may have been doing, and analyzing how much the company is spending on specialty pharmacy services and discussions around how specialty pharmacy is generally handled in the industry and what options are around how health plans tend to handle specialty pharmacy services.
Q. What were the options that were being discussed?
A. **Contracting with particular vendors to provide, you know, exclusive or whatever basis specialty pharmacy services on behalf of our members.**
Q. What analysis was done around these issues?
A. **How much we're spending for different categories of specialty drugs and I believe there was some benchmarking of industry activities around who contracts with various vendors and so forth.**
Q. Who's responsible for performing that analysis?

125

A. **The analysis was performed jointly by our actuarial department and our ancillary provider contracting area.**
Q. Do you recall the names of any of the individuals who were involved in that analysis?
A. **John Killion from our provider contracting area, and I don't remember specifically which of the actuarial people were involved.**
Q. Do you recall what was analyzed around the issue of what's being spent and benchmarking?
A. **I don't understand.**
MR. COCO: Objection.
Q. In terms of the analysis, you described it as is encompassing number one, how much was being spent, two, analysis around benchmarking and three, the issue of who people in the industry are contracting with. Did I write that down correctly?
A. **You did.**
Q. My question is in relation to the first two issues; how much is being spent and around the issue of benchmarking. What, specifically, was being analyzed?

126

MR. COCO: Objection.
A. How much was being spent, we were analyzing for specialty drugs that are considered to be specialty drugs. How much we spend as a health plan both in aggregate and on per member basis.
Q. By spent, are you referring though to the amounts that are reimbursed to the health care providers who administer those drugs to members?
A. Yes.
Q. And what are you referring to when you talk about benchmarking?
A. Looking at how other plans in the industry are providing these services, whether they're contracting on an exclusive basis with a vendor or multiple vendors or how they're providing the services.
Q. Was any analysis performed of the amounts that were currently being spent reimbursing providers for specialty drugs versus the amount that would be spent under a specialty pharmacy program?
A. Yes.
Q. Do you recall who performed that analysis?

127

A. I believe again it was performed by actuarial in conjunction with John Killion's area.
Q. Do you recall what the conclusions were of that analysis?
A. That there were potential savings, but I don't remember any specific numbers in terms of how much could be saved through specialty pharmacy contracting.
Q. Now was that analysis of potential savings broken up? In other words, was it we could save X number if these drugs were subject to specialty pharmacy programs, or was it if we moved all specialty drugs to special pharmacy programs, here's how much we'd save?
A. We looked at specific categories and kinds of drugs.
Q. And within specific categories was the amount of potential savings calculated?
A. There were estimates calculated.
Q. Do you recall whether oncology drugs were one category that was assessed?
A. Yes.

128

Q. Do you recall what the conclusions were of that analysis in relation to oncology drugs?
A. I do not.
Q. Do you recall whether the analysis revealed the potential net savings?
A. Yes, it did.
Q. Do you recall whether that potential net savings on annualized basis was hundreds of dollars, thousands of dollars, millions of dollars?
A. I don't recall.
Q. Do you maintain copies of any of this financial analysis around the specialty pharmacy issue in your files?
A. I do not.
MR. MANGI: For the record, would call for the production of the analysis that's been the subject of this testimony pertaining to specialty pharmacy products and contemplation of potential savings.
MR. COCO: And we request that you put that request in a separate letter.
MR. MANGI: While we're on the topic, I'll

129

also put this in the letter to reiterate the request made at a previous deposition for custodian information as in Exhibit Coneys 001.
MR. COCO: I'm sorry?
MR. MANGI: Did you not hear any of it or all of it?
MR. COCO: You were talking softly. I didn't understand.
MR. MANGI: I'll repeat a request we made at an earlier deposition for custodian information regarding the document that's been marked as Exhibit Coneys 001.
MR. COCO: And could you put that in a follow-up letter?
MR. MANGI: We would be happy also to put that in a follow-up letter.
MR. COCO: Okay.
Q. Could you turn, please, to -- if you look at Exhibit Coneys 001 you'll see on the bottom left there is a number starting with BCBSMA-AWP on the left-hand side of the page?
A. Ah-hah.

130

Q. Could you turn to the page numbered 10598, please? Could you please review that page and let me know when you're ready to proceed?
A. Okay.
Q. At the bottom of that page is a reference to a New York Times article. Do you see that?
A. Yes.
Q. Do you recall that article?
A. I do not.
Q. Do you recall any discussion of that article in the NM3 committee?
A. I do not.
Q. Following that there's discussion that states, "Physicians are able to obtain discounts as high as 86 percent on medications. Plan reimbursement providers for medication is in the range of AWP minus five percent." Is that difference between physicians' drugs acquisition costs and reimbursement an issue that you recall discussed in relation to the implementation of specialty pharmacy programs?
A. I do not.

131

Q. Are you aware of that issue being subject of discussion at BCBS of Massachusetts in any other context?
A. I do not.
Q. Were you aware of the information memorialized on this page before you just read it now?
A. I don't remember seeing it before.
Q. Were you aware of the fact before you read this document that there is a difference between the amount which physicians acquire drugs and the amounts that they were reimbursed?
A. I was not aware of that.
Q. Now looking through the rest of this document is there anything in this document that would give you an understanding as to when or why this was created?
MR. COCO: Objection.
A. Can you ask me that question again?
Q. Sure. Looking through this document is there anything in here that gives you an understanding as to when this would have been

132

created or for what purpose?
A. I don't know.
Q. If we turn to the page marked 10 which is 10601, please, you'll see there is data analysis here dealing with the period of January of '02 until September of '02. Do you see that?
A. Yes, I do.
Q. Is this the time period for which data analysis was being performed when the NM3 committee was considering whether or not to move to specialty pharmacies?
A. I don't remember when NM3 was considering looking at or was looking at specialty pharmacy.
Q. Was it generally in the '02 to '04 time period?
A. That sounds like it could be a good time period.
Q. Is the analysis reflected at page 10 and page 11 the type of analysis that you recall being considered being carried out in contemplation of whether or not the NM3 committee should move to specialty pharmacies?

133

A. Yes.
Q. And turning to the next page which is page 12, are those implementation considerations the same as the issues that the NM3 committee was considering?
A. Yes.
Q. If we turn to the next page, page 13, does that time line look at all familiar?
A. Yes.
Q. What does that time frame appear to be?
MR. COCO: Objection.
A. It appears to be a project time line.
Q. Is this the time line -- is this time line familiar to you as a time line pertaining to the NM3 committee's contemplation of the move to specialty pharmacies?
A. I don't remember the time line, when they were considering it.
Q. Does looking at pages 10 through 13 refresh your recollection as to whether or not this document was created by the NM3 committee or for the NM3 committee as part of its contemplation to move

134

to specialty pharmacies?
A. On Page 13 it refers to a date on which overview of data will be presented to NM3.
Q. Would that indicate that the answer to my question is yes?
A. Yes.
MR. COCO: Objection.
VIDEOGRAPHER: This is the end of tape number two. The time is 12:43. We are off the record.
(Brief Recess.)
Q. Miss Coneys, before the break we were talking about the NM3 committee's contemplation of specialty pharmacy programs, and you described some of the analytical work that was performed.
What happened after the analytical work was complete? What was the next stage in the decision-making process?
MR. COCO: Objection.
A. I'm not sure I understand what you mean by the next.
Q. Well, the issue first came up and was

135

discussed in the NM3 committee before analysis was performed, right?
A. Ah-hah.
Q. Did the NM3 committee request that the analysis be performed?
A. That's how I remember it, yes.
Q. After that analysis was performed at the committee's request, what happened next?
A. The company did pursue -- I can't remember exactly which drugs, but I believe we pursued contracting with specialty pharmacy vendor for certain category of specialty drugs.
Q. Are you aware that the company did not implement specialty pharmacy program for drugs that were physician-administered?
A. I am not aware of that.
Q. Do you know what factors were considered in making the decision to apply specialty pharmacy programs to some drugs, but not others?
A. I know that patient disruption was a major consideration.
Q. Any other considerations that you're aware

136

of?
A. No.
Q. How was it anticipated that patient disruption may be a concern if specialty pharmacies were implemented?
MR. COCO: Objection.
A. Many of the drugs that we were talking about in terms of potential changes in, you know, who we got the drugs from were for conditions that were very complicated conditions and very sensitive and dependent on the medications that the members used and then there was a lot -- the patients become very comfortable with, you know, the process and how their drugs are supplied to them and what they look like and all of those kinds of things, and there was concern about the impact it would have on the members.
Q. If a specialty pharmacy program were implemented, how would that affect the individual member?
A. They may end up getting their drugs from a different vendor than they were getting it from

137

before a specialty pharmacy program would be implemented.
Q. When you use vendor in that context, are you referring to a different side of care?
A. A different supplier of the drug.
Q. Well, patients would not be acquiring specialty drugs themselves, right?
A. In some -- for some conditions the drugs are self-administered.
Q. Well, I'm trying to understand, however, why the program was limited to self-administered drugs and not applied to physician-administered drugs, and the question is what factors lay behind that decision?
MR. COCO: Objection.
A. I, first of all, don't recall that we did limit it to only patient-administered drugs.
Q. I'll ask you to assume that to be true based on other testimony we received from other BCBS witnesses. If that's true, do you have an understanding as to some of the issues that were considered in determining what the parameters of the

138

programs would be?
MR. COCO: Objection.
A. No.
Q. Was patient disruption a concern in relation to physician-administered drugs?
MR. COCO: Objection.
A. I don't remember discussing physician administered drugs.
Q. Do you recall any discussion of a concern that if specialty pharmacy programs were implemented across the board to all specialty drugs, then physicians may stop administering drugs in their offices, patients would have to go to hospitals or other sites of care?
A. I do remember some discussion around that.
Q. Was that a concern to BCBS of Massachusetts?
A. Yes.
MR. COCO: Objection.
Q. Was that a concern for the same reasons you mentioned earlier that patients become comfortable with getting their care in a particular

139

setting?
A. Yes.
Q. Since the original determination as to the scope of the specialty pharmacy program was made by the NM3 committee, has the issue of specialty pharmacies been revisited by the committee?
A. It has not been revisited by NM3. It's being handled elsewhere in the company.
Q. What group or committee is currently tasked with specialty pharmacy issues?
A. I believe it's within the pharmacy management area.
Q. Do you know who's in charge of that area?
A. It's under Deb Devaux.
Q. Do you know whether anyone in Miss Devaux's department, in particular, is responsible for considering issues relating to specialty pharmacies?
A. It used to be John Killion. I don't know that he, for sure, whether he is still responsible. The last time I dealt with specialty drugs he was.
Q. Could I ask you to turn back to Exhibit

140

Coneys 001 to page six of that document, please? There's a section there entitled, "Special Handling, Dosing and Patient Support Requirements." If you take a moment to review that and let me know when you're ready to proceed, please.
Do you recall any discussion of these issues relating to specialty drugs in the NM3 committee?
A. Yes. These were some of the issues that were discussed in terms of patient disruption.
Q. How were these issues considered relevant to patient disruption?
MR. COCO: Objection.
A. Because as it says in here, the specialty drug companies provide clinical support and, as I understand it, the patients become accustomed to dealing with certain people and turning to certain people with questions about their drugs or about the administration or dosage and so forth of the drugs.
Q. When you were the executive director of the Braintree site, do you recall your physicians or your site having to deal with some of these special

141

handling requirements around specialty drugs?
A. I do not.
Q. Do you know whether there were any particular resources or amounts spent on handling specialty drugs by the Braintree site?
A. I don't know.
Q. But as part of your NM3 committee consideration, you did have an understanding of this document that there are particular handling requirements unique to specialty drugs?
MR. COCO: Objection.
A. At least certain specialty drugs.
Q. And those particular handling requirements, if left with a doctor, would impose a higher cost from the doctor, correct?
A. I don't know that.
Q. Well, there's a higher handling cost and someone has to pay, is that a fair statement?
MR. COCO: Objection.
A. Again, I don't -- I don't know what you're asking me.
Q. Okay. Well, let me try and break it down

142

then. You understood as part of your consideration in the NM3 committee that certain specialty drugs have special handling requirements, correct?
A. Right.
Q. Such as the refrigeration and things like that, right?
A. Right.
Q. And you understood also that there was a cost associated with that special handling, correct?
MR. COCO: Objection.
A. I don't -- I don't know that there's a cost associated with it.
Q. Well, for refrigeration you would need a refrigerator and you would have electrical expenses associated with running it, right?
MR. COCO: Objection.
A. I don't know if those are additional expenses beyond what a physician or a patient would have in their home or office.
Q. Are you familiar with the provider of financial strategies work?
A. No, I'm not.

143

Q. Are you aware of the fact that in recent years BCBS of Massachusetts considered whether or not it should change its methodology used for reimbursing physicians for drugs that they administered in their offices?
A. No, I'm not aware of that.
Q. Are you aware that a move was contemplated from AWP-based reimbursement to ASP-based reimbursement in that setting?
A. No, I'm not.
Q. Are you aware that in 1994 BCBS of Massachusetts settled with the government allegations that it had inflated claims in relation to Medicare?
MR. COCO: Objection.
A. I'm not aware of that.
Q. Are you aware of any litigation in 1994 or thereabouts in relation to BCBS of Massachusetts processing of Medicare claims?
A. Again, I was aware there was litigation. I was not familiar with what the terms, you know, of the litigation were, what it was about.

144

Q. Were you familiar with the settlement that was reached regarding those allegations?
A. No.
Q. Are you aware that one aspect of the settlement involved additional monitoring?
A. No.
Q. Are you familiar at all with any monitoring that was implemented as a consequence of that settlement?
A. No.
Q. Did you do anything to prepare for your deposition today?
A. No.
Q. Did you meet with any of your lawyers in preparation for this deposition?
A. I did meet with my attorneys.
Q. Did you meet with both Mr. Coco and Mr. Skwara?
A. Yes.
Q. When did you meet with them?
A. Monday.
Q. How long did you meet with them for?

145

A. One hour.
Q. Did you meet with anyone else in relation to this litigation?
A. No.
Q. Did you review any deposition transcripts in preparation for the deposition?
A. No.
Q. Did you review any documents in preparation for the deposition?
A. No.
Q. In the context of this litigation were you, at any time, asked to search your files for documents?
A. No.
Q. Have you, in fact, searched your files for documents relevant to this litigation?
MR. MANGI: For the record we'd ask a search of Miss Coneys' files be carried out. We were under the impression that a search had been carried out, and no responsive documents have been found.
We reserve the right to call back the

146

witness if documents are subsequently discovered.
Q. I'd like to ask you about the BC65 program we touched on earlier. BC65 you were responsible for deals with the government in relation to that program from '97 to 2001 when you were the VP for government programs, correct?
A. Correct.
Q. As the VP for government programs did you have any responsibilities in relation to that program other than dealing with the government in relation to that capitated rate?
A. I'm sorry. Could you explain what you mean?
Q. Sure. One aspect of your work was dealing with the government in relation to issues stemming from the BC65 program, correct?
A. Correct.
Q. That included the rate, the capitated rate that the government would pay to BCBS of Massachusetts, did it?
A. It included the supplemental premium that we were charged members.

147

Q. Did it also include determination of the rate, the capitated rate that CMS would pay to BCBS of Massachusetts?
A. I didn't discuss that directly.
Q. Did you have a role in relation to the operation of the BC65 program, itself, in terms of contracting with physicians, product design, things of that kind?
A. I had. I was involved in product design, network design, but not contracting with physicians.
Q. After 2001 when you became the VP for health care quality and cost, did you retain any role in relation to the BC65 program?
A. I did.
Q. I'm sorry?
A. I did retain.
Q. What were the responsibilities that you retained in relation to the BC65 program?
A. I retained the same responsibilities I had prior to 2000.
Q. Do you know when the BC65 product was launched?

148

A. I don't remember the date.
Q. Do you know the year or the time period?
A. I don't remember.
Q. Was it prior to 2000?
A. Yes.
Q. Was it prior to your coming into the role as VP of government --
A. Yes.
Q. Is that still in existence today?
A. Yes.
Q. Do you know what methodology BCBS of Massachusetts uses to reimburse physicians who treat patients under the BC65 product?
A. It's fee for service.
Q. Do you know how the fees are calculated on those fee schedules?
A. I do not.
Q. Are you aware that in recent years BCBS of Massachusetts contemplated changing the methodology that was used to calculate the amount to reimburse to physicians treating patients covered by the BC65 product?

149

A. No.
MR. COCO: Objection.
Q. Are you familiar with the term, ASP?
A. No.
Q. Are you aware of the fact that Medicare has recently changed the methodology whereby it calculates the amount reimbursed to physicians for drugs administered in their offices?
A. No.
Q. Do you know whether or not the reimbursement methodology utilized for the BC65 product has changed over time or has remained the same?
A. I don't know.
Q. Do you have any responsibility in relation to communications between BCBS of Massachusetts and physicians in specific to the BC65 product?
A. No.
Q. Do you review such communications before they go out?
A. No.
Q. We spoke about drugs. Do you know whether

150

the amount reimbursed to physicians for services rendered in treating patients covered by the BC65 product has changed over time?
A. I don't know.
MR. MANGI: Let's mark this as Exhibit Coneys 002.
(Boston Globe Article dated 6/29/00 marked Exhibit Coneys 002.)
Q. Now this is an article from the Boston Globe from June of 2000 that quotes you. Are you familiar with this article?
A. I don't remember.
Q. Take a moment and familiarize yourself with it, and let me know when you're ready to proceed, please.
A. Okay.
Q. Does reading this article refresh your recollection as to whether or not you've seen it before?
A. I've seen it before.
Q. Now I believe this discusses an issue you referenced earlier regarding premiums and

151

supplemental premiums, is that correct?
A. Right, right.
Q. When the BC65 product first launched and when you were first familiar with it, were premiums being charged to members?
A. You know, I don't remember when the product was first launched, whether there was a supplemental premium or not. As far as I can remember for the period of time that I was responsible for it there was a premium.
Q. Is that a -- were those monthly premiums paid by members?
A. Yes.
Q. From the patient's perspective are those premiums different from what they would have paid if they enrolled in Medicare directly?
A. To enroll -- to enroll in an HMO plan they have to be enrolled in Medicare. If they were to buy supplemental coverage, then what we were charging was less than what they would have to pay if they bought supplemental coverage for a metigap (phonetics) product, but in line sometimes less

152

expensive, sometimes more expensive than other HMO products that were on the market.
Q. The BC65 program offered members the various options in terms of the level of coverage they would receive, correct?
MR. COCO: Objection.
A. I believe initially when the product was launched there were two different products; one that had drugs and one that did not. Eventually during the time I was running the product we were only offering one product option.
Q. Was that the option with drugs or without drugs?
A. With drugs.
Q. Looking at the first page of this article, the second paragraph from the bottom, refers to Miss Patty Blake, Secure Horizons, who said that the rates Medicare pays Tufts to care for seniors is so low that the HMO has little choice but to establish across-the-board premiums. Was a similar dynamic in play leading to the premiums charged by BCBS of Massachusetts?

153

A. Yes.
MR. COCO: Objection.
Q. Was a concern over the adequacy of the capitated rate paid directly by Medicare that played a role in the setting in increases to monthly premiums charged to members, right?
A. Correct.
Q. Second page of this document there's a paragraph in the middle of the page starting with, "For example, Blue Cross Blue Shield." Do you see that?
A. Ah-hah.
Q. It says the HMO pays $500 a year per senior for drugs and members cover the rest. What is meant by that?
A. It means that the plan, Bluecare 65, would pay for $500 worth of drugs, prescription drugs, and anything over that the member would be responsible for paying on their own.
Q. Was there always a -- well, how long was this $500 cap on drugs spending in effect?
A. I don't remember specifically how long we

154

had a $500 drug benefit.
Q. How long has there been a cap?
A. For several years, but I don't remember exactly when it began being capped.
Q. Has the amount changed over time?
A. It has.
Q. What's the current?
A. I believe it's $600.
Q. Does that amount include both self-administered drugs as well as physician-administered drugs?
A. No. It includes only prescription drugs.
Q. By prescription drugs you're referring to self-administered drugs?
A. Correct.
Q. Physician-administered drugs are covered under BC65 and are not subject to this cap?
A. That's right.
Q. Turning to the third and last page of that document here's a section where it refers to you and quotes you. You indicated that Blue Cross Blue Shield wanted to expand BC65 to new parts of western

155

Massachusetts if you could convince providers to sign onto the program. Now this article is from June of 2000. Since that time has the BC65 program been expanded?
MR. COCO: Objection.
A. I actually don't know. I can't remember whether we ever did expand in that area or not.
Q. You say in this quote here, "There are a limited number of providers and a reluctance to contract with Medicare plans. It's more of a financial risk for them." What did you mean by that?
A. The providers -- I'm trying to think back to what I meant. I believe what I was referring to here was just not physician providers, but hospital providers as well that we -- that for providers, hospital providers who are in the network, our reimbursement motto was per diem motto and Medicare or DRG -- I can't really tell you exactly what I meant.
I don't know what I was responding to or what question she asked me when I said this, so I'm

156

not sure what I meant by it's more of a financial risk for them.
Q. Okay. Well, let's stick with the first part of sentence for a minute. There's limited number of providers. Fair enough. Then you refer to a reluctance to contract with Medicare plans. Do you know why providers were reluctant to contract with Medicare plans?
A. There were additional rules that were required in terms of again referrals and patient management that are typical to an HMO that don't exist in a traditional Medicare program, so there was more administrative.
Q. Anything else?
A. Different plans have different reimbursement methods. I believe that they pay to the providers and some of them did do capitations I think particularly back in this period of time, and physicians didn't want to be at risk for, you know, the cost and use of Medicare beneficiaries.
Q. Were you expressing here a view that providers -- that contracting with Medicare plans

157

was financially less attractive to providers than contracting with private plans?
MR. COCO: Objection.
A. It wouldn't be contracting with private plans. It would just be being part of the Medicare program.
Q. So the comparison you're making here is between a provider who will contract with a managed Medicare product with a plan like BCBS Massachusetts versus a provider who will deal directly with Medicare?
A. Right.
Q. And you indicated that dealing with a managed Medicare product provider like BCBS of Massachusetts would be more of a financial risk for a physician than dealing directly with Medicare?
MR. COCO: Objection.
A. Again, I don't remember what I was referring to when I talked about financial risk.
Q. Let me just clarify the question. I understand you don't know specifically what you were referring to when you said financial risk. I'm just

158

trying to understand the comparison you were making.
In other words, regardless of what you meant were you saying there is more of a financial risk for providers when dealing with managed Medicare product through an entity such as Blue Cross Blue Shield versus contracting directly with Medicare, or were you drawing some other comparison?
MR. COCO: Objection.
A. I was saying that it's more complex for them to deal with an HMO in terms of the demands around patient management and so forth that go with being part of an HMO.
Q. And you don't recall what you meant or don't understand what you meant when you referred to financial risk in this context?
A. I don't.
MR. COCO: Objection.
MR. MANGI: Why don't we take a break?
(Brief Recess.)
Q. Miss Coneys, we spoke about the VP for healthcare quality part of your job. I'd like to ask you about the VP for cost as part of your title.

159

What does that aspect of your role involve?
A. It relates to utilization review and care management programs.
Q. What are care management programs?
A. Disease management, case management, coaching programs.
Q. Does BCBS perform any analysis of the amount it's spending in terms of drug reimbursement?
MR. COCO: Objection.
A. We look at prescription drug utilization and cost.
Q. Does that include both self-administered drugs and physician-administered drugs?
A. No, it doesn't include physician-administered drugs.
Q. Those are specifically excluded from the analysis?
A. I don't believe they are prescription drugs.
Q. So the only analysis that you're familiar with excludes physician-administered drugs?
A. Yes.

160

Q. Turning back for a moment to the BC65 program, we mentioned in this article that there was a $500 cap at one point on drug --
A. Right.
Q. -- coverage. Did I understand correctly that the only BC65 product offered now is a product that includes drug coverage?
A. I believe that's still true.
Q. In other words individuals don't have an option to enroll in a BC65 program that would exclude drugs?
MR. COCO: Objection.
A. I don't believe so.
Q. In addition to the supplemental payments that they're making, do the BC65 members also have coinsurance or copayment obligations?
A. Yes.
Q. How are those amounts calculated?
A. I'm sorry?
Q. How are those amounts calculated?
A. They're determined as part of the benefit design process.

161

Q. Are they flat co-pays or percentage co-insurance?
A. They're co-pays.
Q. $5 sums?
A. Yes.
Q. Do you know whether Blue Cross Blue Shield of Massachusetts contracts with physicians -- withdraw that -- contracts with drug manufacturers?
A. No.
Q. Are you familiar with the P&T committee of pharmacy and therapeutics committee?
A. I know there is one.
Q. Are you a part of that committee?
A. No.
Q. You ever been a part of that committee?
A. No.
Q. Do you have any knowledge or understanding as to the amount at which entities in the market, be they physicians, hospitals, anyone else, acquired drugs?
A. No.
Q. Do you have an understanding as to whether

or not or to what extent discounts and rebates are available on drugs to purchasers in the market?

A. I do not.

Q. Are you familiar or have you heard the term W-A-C, WAC, or wholesale acquisition cost?

A. No.

MR. MANGI: Okay, I have nothing further.

MR. COCO: Did you have anything?

MR. MIZELL: No.

MR. COCO: Okay. Just for the record during the break we did review the fact that even though Miss Coneys does not remember it, that a request was made to her to search for documents and a response was received that she did not have any, but she has no recollection of that.

We believe it was about the time you served the notice for her deposition, so that is the basis for, you know, my representations that a search had been done and she was not aware, but we will go back and just double-check that to make sure that that was done.

MR. MANGI: I appreciate the clarification

and we'd request that either the search be re-performed with reference to the entirety of the document request or that documentation reflecting that the search was previously performed, one or the other, in light of the testimony. Okay. Nothing further.

(Whereupon the deposition concluded at 1:44 p.m.)

_____

MAUREEN CONEYS

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____

Notary Public

Commonwealth of Massachusetts
South Middlesex, ss.

I, Teresa E. Costello, Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 12th day of April, 2006, MAUREEN CONEYS, who was duly sworn by me; that the ensuing examination upon oath of the said deponent was reported stenographically by me and transcribed into typewriting under my direction and control; and that the within transcript is a true record of the questions asked and answers given at said deposition.

I FURTHER CERTIFY that I am neither attorney nor counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or financially interested in the outcome of the action.

IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal of office this 14th day of April, 2006, at Framingham.

Teresa E. Costello, RPR,
CSR, #1452S98
Notary Public, Commonwealth of Massachusetts
My Commission Expires: 5/29/09